Chemung
FAMILY DENTAL
Richard B. Dunn, DDS
1007 Broadway
Elmira, NY 14904
(607) 734-2045
www.ChemungFamilyDental.com

DENTURE HEALTH HISTORY

Patient's Name: ______________________ Birth Date: ________ Today's Date: ________
Address: ______________________ City: ____________ State ____ Zip ________
Marital Status: ______________________ Home Phone: ______________________
Place Of Employment: ______________________ Business Phone: ______________________
Email: ______________________ Cell Phone: ______________________
Physician's Name: ______________________ Referred To Us By: ______________________
Dental Insurance Co. Name: ______________________
Most Convenient Day & Time For Your Dental Appointments: ______________________
Purpose of This First Dental Visit: ______________________

Person Financially Responsible For This Account: ______________________

____
Address: ______________________ *Home Phone:* ______________
Employment Name & Address: ______________________ *Social Security No.:* ______________

Emergency Contact ______________________ *Phone* ______________________
Is it okay to contact your Emergency Contact with your present medical condition? ____ *Yes* ____ *No*

Please check the best answer, and complete the blank lines where appropriate:

- Are you under any medical treatment now or within the past 5 years? . . . . ____ Yes ____ No
  If YES, for what problems? ______________________
- Have you ever had treatment for your gums? . . . . ____ Yes ____ No
- Has worry ever kept you from seeking dental care? . . . . ____ Yes ____ No
- Are you allergic or sensitive to any medications? . . . . ____ Yes ____ No
- Are you continually troubled with bad spells of sneezing, stuffed-up nose, hay fever, etc.?. . . . ____ Yes ____ No
- Would wearing false teeth disturb you greatly? . . . . ____ Yes ____ No
- Has a physician ever said your blood pressure was too low, or too high? . . . . ____ Yes ____ No
  If YES, which one?. . . . . ____ High ____ Low
- Do you suffer from constant stomach trouble? . . . . ____ Yes ____ No
- Are you taking any medication? If YES, please list ______________________ ____ Yes ____ No
- Are you considered a nervous person? . . . . ____ Yes ____ No
- Would you like to know more about implants to stabilize dentures?. ____ Yes ____ No
- Have you frequently been confined to bed?. . . . . ____ Yes ____ No
- Have you gained or lost much weight lately? . . . . ____ Yes ____ No
- Have you ever had a series of injections other than for immunization purposes?
- Do you smoke? . . . . ____ Yes ____ No
- Are you constantly keyed-up and jittery? . . . . ____ Yes ____ No
- Has a physician ever said that you had: stomach ulcers, diabetes, tuberculosis, rheumatic fever, cancer, anemia, kidney, bladder, lever or heart trouble, bleeding disorders, hepatitis, asthma, immune system diseases, communicable diseases?
  If YES, please list: ______________________
- Have you had any major operations in the last 10 years? . . . . ____ Yes ____ No

Do you suffer from frequent or sick headaches? . . . . ____ Yes ____ No
How long since you have had a complete physical examination? . . . . ____ Yes ____ No
Have you had a joint replacement - ____knee____ hip ____ shoulder and/or ____ toe? . . . . . . ____ Yes ____ No

Are you interested in dental implants (fixed tooth replacement)? . . . . ____ Yes ____ No

-If you presently are wearing dentures are you happy with their:

Appearance ____ Yes ____ No   Function ____ Yes ____ No

Do you snore or have you been told you snore?. . . . . ____ Yes ____ No

Do you still have your tonsils?. . . . . ____ Yes ____ No

Do you wake up often when you are sleeping?. . . . . ____ Yes ____ No

Do you wake up from a night's sleep feeling refreshed or do you feel tired and groggy?. . . . . ____ Yes ____ No

Do you fall asleep during the day when you don't want to? For ex.-driving the car, stopped in traffic, watching TV, reading or just sitting down?. . . . . ____ Yes ____ No

Have you ever had a sleep study performed?. . . . . ____ Yes ____ No

Do you currently have a CPAP machine? Do you use it every night?. . . . . ____ Yes ____ No

Have you ever been diagnosed with a sleep disorder such as OSA(Obstructive Sleep Apnea) . . . . ____ Yes ____ No

Do you have any particular mouth habits listed among the following? Please circle which ones apply.
Foreign objects betw**een teeth? • Biting lip**s, cheek, tongue**, fingernails? • Clenching** t**eeth? • Grinding** teeth at nigh**t? •**
Awake in morning with teeth t**ogether? •** Aches in joint-fac**e muscles? • Ear p**roblems?

Other: ____

Denture History   *Thank You!*